

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. That please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15738

15738

1. PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 13.1	
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 14 Ridge Road		e. STREET ADDRESS 14 Ridge Road		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY FREDERICK CAVEY Sr		4. DATE OF DEATH Nov. 21, 1966		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 5, 1897	
9. AGE (in years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Barber		11. BIRTHPLACE (County & State, or foreign country) Grays, Md	
12. CITIZEN OF WHAT COUNTRY? Grays, Md		13. FATHER'S NAME William J. Cavey		14. MOTHER'S MAIDEN NAME Carrie King	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. John W. Warfield, Box 281 Rt. 5, Annapolis	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Cardio-vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 5 min. 5 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-20 , 19 58 , to 11-21 , 19 66 , that (II) (we) last saw the deceased alive on 11-15 , 19 66 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.		22a. SIGNATURE Thomas F. Herbert, M.D.		22b. DATE SIGNED 11-22-66	
22c. PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.		22d. ADDRESS 44 Church Rd. Ellicott City, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 11-23-1966		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd		23d. LOCATION (City, town or county) (State) Ellicott City, Md	
24. FUNERAL DIRECTOR F.C. Higginbotham, Ellicott City, Md.		25a. REC'D BY REGISTRAR NOV 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15736						15739					
1. PLACE OF DEATH a. COUNTY Howard						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge				c. LENGTH OF STAY IN ID 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge 131					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Meadowridge Ave						d. STREET ADDRESS Meadowridge Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LILLIAN BELLE DAVIS						4. DATE OF DEATH Nov. 21, 1966 19 19					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec/ 16/ 1885		9. AGE (In years last birthday) 80 yrs.		10. UNOER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Belair- Ohio			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Perry E. Lovejoy						14. MOTHER'S MAIDEN NAME Mary Elizabeth Main					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. NONE		17. INFORMANT James L. Davis- Meadowridge Ave.-Elkridge-					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular disease 4221 DUE TO clonfirmities of age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO Senile Dementia (b) (c) INTERVAL BETWEEN ONSET AND DEATH 5 1/2 yrs 6 mo											
PART II. OTHER SIGNIFICANT CONDICTIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDICTION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Jan , 1964, to Nov , 1966, that (I) (we) last saw the deceased alive on Nov 20 1966 , and that death occurred at 12 30 M, from the causes and on the date stated above.											
22a. SIGNATURE B B Brumbaugh M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/21/66			
22c. PHYSICIAN'S NAME (Type) B B Brumbaugh						22d. ADDRESS 5609 Main St Elkridge Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Nov. 23-1966		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Md. 21701			
24. FUNERAL DIRECTOR M.R. Etchison & Son						ADDRESS Whitmore Frederick, Md.		25a. REC'D BY REGISTRAR NOV 22 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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FOR STATE
HEALTH DEPT

15737

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15740

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit receipt. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenelg c. LENGTH OF STAY IN lb 13-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenelg d. STREET ADDRESS 13-1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last ANNIE MERCER DAY			4. DATE OF DEATH Month Day Year November 28, 1966		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1885	9. AGE (In years last birthday) yrs. 81	IF UNDER 1 YEAR Months Days Hours Min. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Glenelg, Md	
13. FATHER'S NAME Joshua B. Day			12. CITIZEN OF WHAT COUNTRY?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Mr. Marvin Day, Glenelg, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Whitaker		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 11/29/66	
EXAMINER'S NAME (Type) Charles S. Whitaker, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) Howard			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 1, 1966		23c. NAME OF CEMETERY OR CREMATORY Providence	
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md		23d. LOCATION (City or Town) (County) (State) Glenelg, Md		25a. REC'D BY REGISTRAR DATE NOV 30 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge			

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1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		131	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pine Orchard-Ellicott City				d. STREET ADDRESS Pine Orchard-Ellicott City		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillie May Dosh		First		Middle		Last	
				4. DATE OF DEATH Month Nov. 19		Day 19	
5. SEX F		6. COLOR OR RACE Wh		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 6, 1887	
				9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Late-Samuel Hyde		14. MOTHER'S MAIDEN NAME Late-Diehlman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Wilbur H. Dosh Pine Orchard - Ellicott City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular occlusion 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 30 min 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-21 , 19 59 , to 11-19 , 19 66 , that I last saw the deceased alive on 11-17 , 19 66 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas F. Herbert		M.D. 44 Church Rd. Ellicott City, Md.		DATE SIGNED 11-19-66			
PHYSICIAN'S NAME (Type) Thomas F. Herbert				Church Rd.-Ellicott City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-66		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D.-4101 Edmondson Ave.		ADDRESS Ave.		24a. REC'D BY REGISTRAR NOV 22 1966		24b. REGISTRAR'S SIGNATURE Charles J. Jones	

VS A15 (4)
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CHARTER - OF DEATH

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FOR STATE
HEALTH DEM.

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VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15739

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15742

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lisbon			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 40				d. STREET ADDRESS 328 King George Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle A. Last FUNDERBURK				4. DATE OF DEATH Month November Day 3 Year 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 11, 1915		9. AGE (In years last birthday) yrs. 51	IF UNDER 1 YEAR Months 02 Days 23 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor		10b. KIND OF BUSINESS OR INDUSTRY State of Maryland		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Funderburk				14. MOTHER'S MAIDEN NAME Hattie Curry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Mrs. Doris F. Funderburk, 328 King George Dr			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Traumatic Injuries. 8234 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Ethylism.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto which ran off roadway.					
20c. TIME OF INJURY Hour 5:30 p.m. Month, Day, Year 11/3 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Lisbon Howard Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty, M.D.		22. DATE SIGNED 11/4/66				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-7-66		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue, 21229				25a. REC'D BY REGISTRAR DATE NOV 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15740

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15743

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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1 PLACE OF DEATH a. COUNTY Howard MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b Ellicott City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 121 Turf Valley Rd.		d. STREET ADDRESS 121 Turf Valley Rd.	
3 NAME OF DECEASED (Type or print) First PRISCILLA Middle HART Last GERNON		4 DATE OF DEATH Month November Day 5 Year 1966	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-19-1920
9 AGE (In years last birthday) 46		10 IF UNDER 1 YEAR Months 5 Days 19 Hours 66 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Fall River, Mass		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Gardiner Hart		14 MOTHER'S MAIDEN NAME Edith Coolridge	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. ?	
17 INFORMANT Frank Gernon, 121 Turf Valley Rd. Ellicott		Address City	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia due to carbon monoxide 101 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Asphyxia by carbon monoxide from car exhaust	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11-5 p.m. 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Garage of home		20f. (City or town) (County) (State) Ellicott City, Howard, Md.	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		22. DATE SIGNED 11-5-66	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-8-1966	23c. NAME OF CEMETERY OR CREMATORY St. Johns	23d. LOCATION (City or Town) (County) (State) Ellicott City, Md
24 FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md		25a. REC'D BY REGISTRAR NOV 9 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

1971

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15741 **CERTIFICATE OF DEATH** **15744**

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>		c. LENGTH OF STAY IN ID <u>Years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Route 32</u>			d. STREET ADDRESS <u>Route 32</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Phyllis Elizabeth Gosnell</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1966</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-31-1912</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Edward Cavey</u>			14. MOTHER'S MAIDEN NAME <u>Priscilla Gearhart</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-42-0041</u>		17. INFORMANT <u>Mr. Eugene Gosnell</u> Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <u>5 - 10 min.</u> <u>2+ yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that (I) deceased attended the deceased from <u>1935</u> , 19 <u> </u> to <u>9/Nov/66</u> , 19 <u> </u> , that (I) was last saw the deceased alive on <u>9/Nov/66</u> 19 <u> </u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>W. H. Lawson, Jr.</u>			22b. DATE SIGNED <u>9/Nov/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M. D.</u>			22d. ADDRESS <u>Box 54, RD #2, Sykesville, Maryland</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-12-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>M.T. View Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Howard Co. Md.</u>
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>			25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

1978

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15742

15745

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Jessup		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oxford	
c. LENGTH OF STAY IN 1b 11 yr 11 mo.		d. STREET ADDRESS Box 52, South Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Patuxent Institution		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle M. Last Haddaway		4. DATE OF DEATH Month November Day 22 Year 19 66	
5. SEX male	6. COLOR OR RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-21-12
9. AGE (in years last birthday) 54 yrs.		10. IF UNDER 1 YEAR: Months 54 Days 22 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) caretaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Oxford, Talbot Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Julius Haddaway		14. MOTHER'S MAIDEN NAME Lillian Hill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 6/41 to 11/45		16. SOCIAL SECURITY NO. unkn.	
17. INFORMANT Mrs. Norman Grimes, 1159 Sargent St.		Address Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO (b) Atrial Fibrillation DUE TO (c) Arteriosclerotic Cardiovascular Disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 5 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) was not attended the deceased from 8-4-66 , 19 66 to 11-22 , 19 66 , that (I) was last saw the deceased alive on November 22 , 19 66 , and that death occurred at 4:50 P M, from the causes and on the date stated above.			
22a. SIGNATURE Domingo C. Sorongon M.D.		22b. DATE SIGNED 11-22-66	
22c. PHYSICIAN'S NAME (Type) Domingo C. Sorongon, M.D.		22d. ADDRESS Patuxent Institution, Jessup, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/26/1966	23c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery	23d. LOCATION (City, town or county) (State) Oxford, Maryland
24. FUNERAL DIRECTOR MAURICE E. NEWMAN & SON, Easton, Md.		25. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12721

1 (M)
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
35D0 4-64

15743

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 15740

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - Dayton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - Dayton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Howard Road		d. STREET ADDRESS Howard Road	
3. NAME OF DECEASED (Type or print) Fenton Cefus Johnson		4. DATE OF DEATH Month Nov Day 5 Year 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-16-1889
9. AGE (in years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Algernon Johnson		14. MOTHER'S MAIDEN NAME Mary Elizabeth Grimsley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-32-3514	
17. INFORMANT Mrs. Leola Johnson		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO (b) Coronary thrombosis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH instant. instant.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Whitaker, M.D. EXAMINER'S NAME (Type) Charles S. Whitaker, M.D. Clarksville, Maryland		22. DATE SIGNED 11-6-66 Address (Street, city, town, or county) Howard	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-9-66	23c. NAME OF CEMETERY OR CREMATORY Jennings Chapel	23d. LOCATION (City, town or county) (State) Jennings Chapel Howard Md.
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 10 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

1944

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

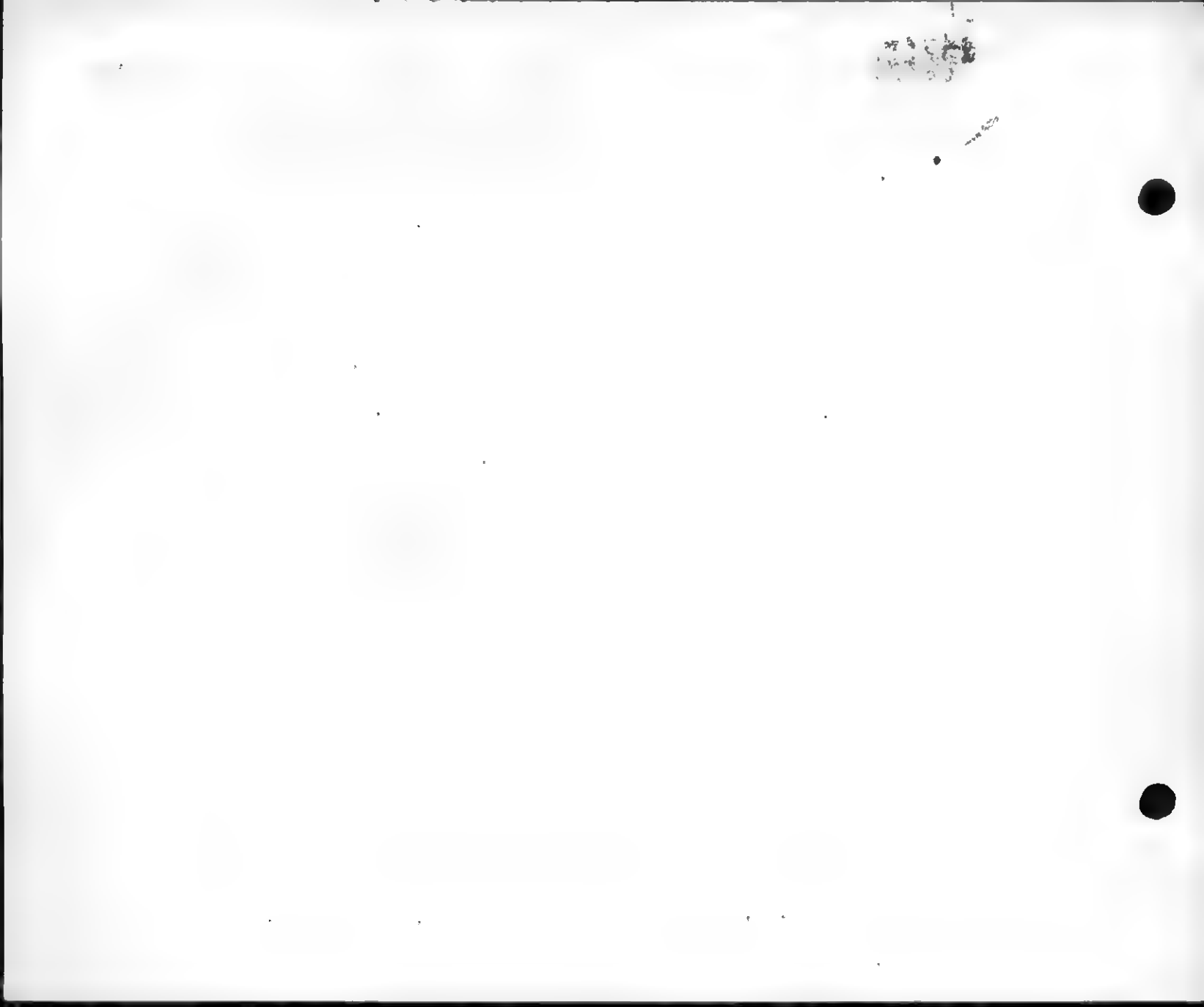
FOR STATE
HEALTH DEPT

15744

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15747

1 PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) One Spot				c. LENGTH OF STAY IN 1b Jessup			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Rte. 1, S. of 175				d. STREET ADDRESS Box 255, Cedar Avenue			
3. NAME OF DECEASED (Type or print) First HEZEKIAH Middle KENNEDY Last KENNEDY				4. DATE OF DEATH Month November Day 16 Year 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1913	9. AGE (In years last birthday) 54 3/4 yrs	10. UNDER 1 YEAR Months 1 Days 19		11. UNDER 24 HRS Hours 66 Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinery Operator			10b. KIND OF BUSINESS OR INDUSTRY Sand & Gravel Co.		11. BIRTHPLACE (State or foreign country) Augusta Co., Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James F. Kennedy				14. MOTHER'S MAIDEN NAME Lucy F. Colvin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 723-18-7869		17. INFORMANT Address Mrs. Rose Kennedy, Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Traumatic Injuries. 812.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Pedestrian struck by auto.				
20c. TIME OF INJURY Month, Day, Year Hour 8:30 pm 11/16 19 66			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Street		20f. (City or town) (County) (State) One Spot Howard Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			22. DATE SIGNED 11/17/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 20, 1966		23c. NAME OF CEMETERY OR CREMATORY Bell Valley Cemetery,		23d. LOCATION (City or town) (County) (State) Goshen, Virginia	
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland				25a. REC'D BY REGISTRAR DATE NOV 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

15748

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Schaeffer Conv. Home				d. STREET ADDRESS 522 Edgewood St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Maria Middle Maggenti Last Maggenti				4. DATE OF DEATH Month Nov. Day 18 Year 1966			
5. SEX F		6. COLOR OR RACE Wh		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 2, 1885	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 18 Hours 19 Min.		IF UNDER 24 HRS Months 81 Days 18 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Ridolfi				14. MOTHER'S MAIDEN NAME Unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. Mr. Mario Maggenti 1910 Brookdale Rd.			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular occlusion DUE TO Arteriosclerotic Cardio-vascular disease Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO 10 years				INTERVAL BETWEEN ONSET AND DEATH 48 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1-10 , 19 66 to 11-18 , 19 66 , that I last saw the deceased alive on 11-18 , 19 66 , and that death occurred at 5:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 44 Church Rd. - Ellicott City, Md. DATE SIGNED 11-19-66							
ACTUAL SIGNATURE Thomas F. Herbert M.D.							
PHYSICIAN'S NAME (Type) Thomas F. Herbert				44 Church Rd. - Ellicott City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-66		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md. Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D.-4101 Edmondson Ave.				24a. REC'D BY REGISTRAR DATE NOV 22 1966		24b. REGISTRAR'S SIGNATURE Charles Judge	

1944



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

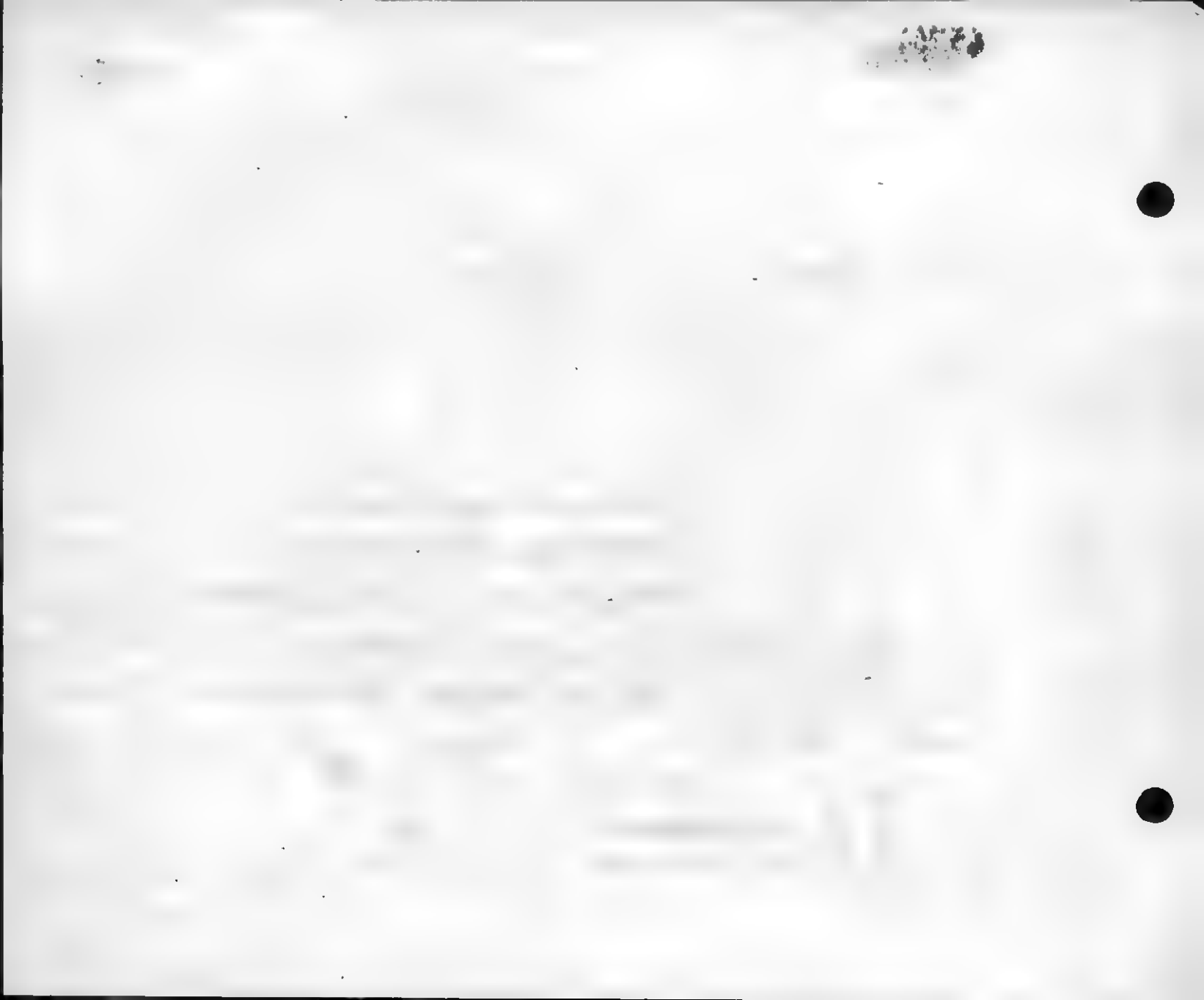
15746

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15749

1 PLACE OF DEATH a. COUNTY <u>Harward</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Harward</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Simpsonville</u>		c. LENGTH OF STAY IN 1b <u>15.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>114 Hunting Lane</u>		d. STREET ADDRESS <u>114 Hunting Lane</u>	
3 NAME OF DECEASED (Type or print) <u>CHARA IZORA O'NEILL</u>		4 DATE OF DEATH Month <u>Nov</u> Day <u>11</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>April 7, 1901</u>
9 AGE (In years last birthday) <u>65</u> yrs		10 UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>superintendent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Womens Prison</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Hagerstown Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wilbur Baechtel</u>		14. MOTHER'S MAIDEN NAME <u>Edna Semler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>7 Mrs Gilbert Athey</u>	
17. INFORMANT <u>Mrs Gilbert Athey</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO (b) <u>Thrombophlebitis</u> DUE TO (c) <u>Fractured Fibula Head.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 wk.</u> <u>4 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia 2 days</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF OTHER NOTIFY MEDICAL EXAMINER) <u>Fell at home and injured R. knee.</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour: <u>12:30</u> p.m. <u>10/17</u> 19 <u>66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Jessup Hon. Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/17</u> , 19 <u>66</u> to <u>11/11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/11</u> , 19 <u>66</u> , and that death occurred at <u>5P</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>J M Warren</u>		22b. DATE SIGNED <u>11/11/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J M Warren</u>		22d. ADDRESS <u>Laurel PG Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/14/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem</u>	23d. LOCATION (City or town) (County) (State) <u>Laurel PG Md.</u>
24. FUNERAL DIRECTOR <u>De Witt Conradson</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 15 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15747

15750

1. PLACE OF DEATH

a. COUNTY

Howard

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hammond Village

c. LENGTH OF STAY IN

1 YR + 1 MO.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2906 Gorman Rd (LAUREL)

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Howard

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hammond Village

d. STREET ADDRESS

2906 Gorman Rd

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

Helene

First

M.

Middle

Schmid

Last

4. DATE OF DEATH

Month

Day

Year

Nov

27

19 66

5. SEX

F

W

6. COLOR OR RACE

7. MARRIED

☒ NEVER MARRIED ☐

8. DATE OF BIRTH

Sept 15 - 1924

9. AGE (in years last birthday)

42 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

217-14-2184

11. BIRTHPLACE (County & State, or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Skrupski

14. MOTHER'S MAIDEN NAME

Josephine JARKIEWICZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-14-2184

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DU TO

(b)

DU TO

(c)

pulmonary insufficiency
Carcinoma of lung

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 11-5, 1966 to 11-27, 1966 that (I) (we) last saw the deceased alive on 11-24, 1966 and that death occurred 2:40 AM, from the causes and on the date stated above.

22a. SIGNATURE

Melton D. Witzke

M.D.

ATTENDING PHYS.

☒

MED. DIRECTOR

☐

STAFF PHYS.

☐

22b. DATE SIGNED

11-27-1966

22c. PHYSICIAN'S NAME (Type)

Melton D. Witzke, M.D.

22d. ADDRESS

4140 Sandy Spring Rd Burtonsville Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

11/30/66

23c. NAME OF CEMETERY OR CREMATORY

MEADOWRIDGE

23d. LOCATION (City, town or county)

DORSEY, MD.

24. FUNERAL DIRECTOR'S SIGNATURE

Harry H. Witzke

ADDRESS

321 Columbia Pike
Baltimore City Md.

25a. RECD BY REGISTRAR

NOV 25 1966

DATE

25b. REGISTRAR'S SIGNATURE

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and, in any event, within 72 hours after death.

2005

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MARYLAND STATE DEPARTMENT OF HEALTH

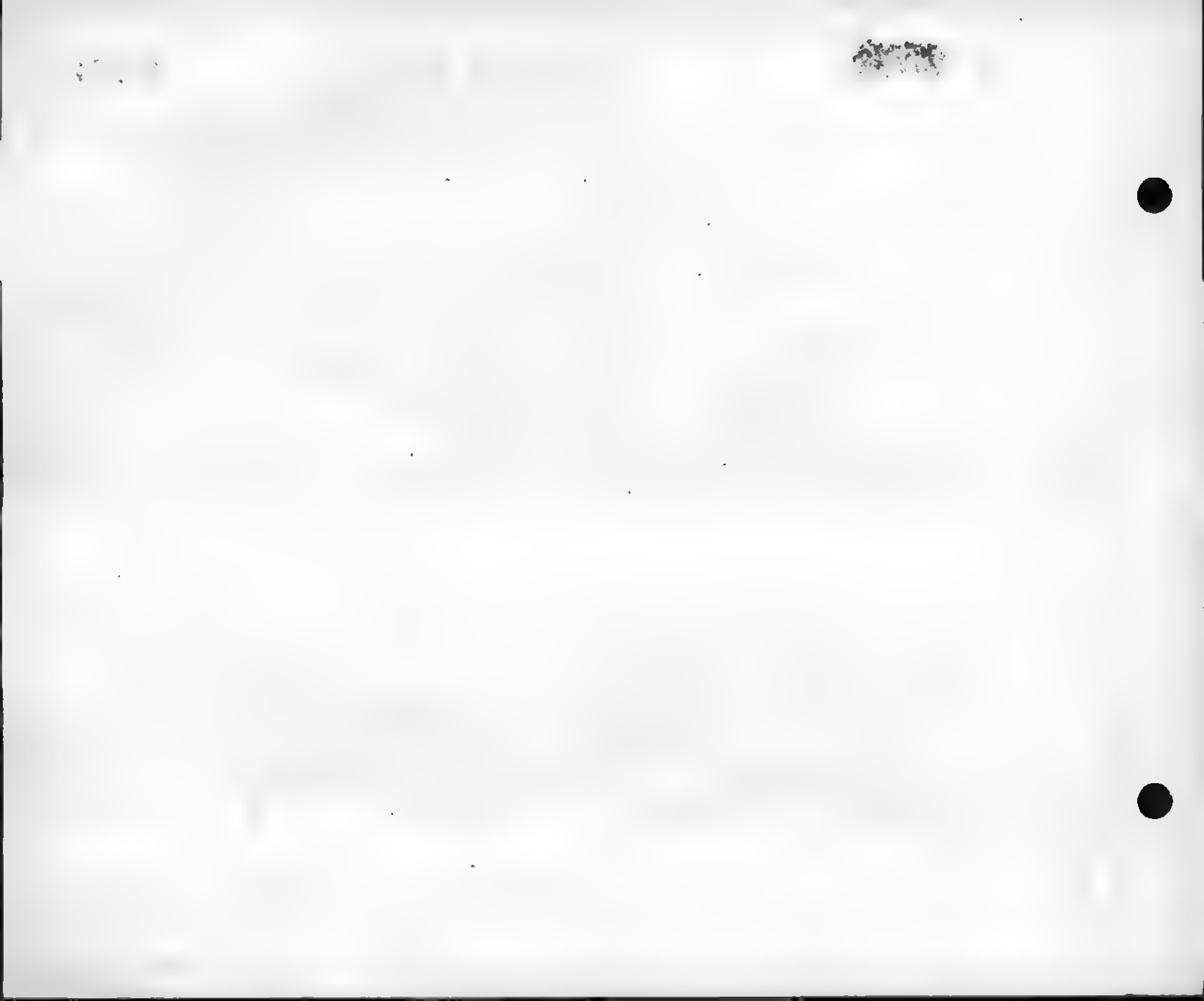
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15748

CERTIFICATE OF DEATH

15751

1 PLACE OF DEATH a COUNTY Howard		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c LENGTH OF STAY in lb 7 Mos.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shaeffers Retreat Conv. Home		d STREET ADDRESS 3120 Rolling Road	
3 NAME OF DECEASED (Type or print) Ethel V. Smink		4 DATE OF DEATH November 3 1966	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-9-1875
9a USUA. OCC. PAT ON (Give kind of work done during most of working life, even if retired) At Home		9b KIND OF BUSINESS OR INDUSTRY Baltimore County	
10a USUA. OCC. PAT ON (Give kind of work done during most of working life, even if retired) At Home		10b KIND OF BUSINESS OR INDUSTRY USA	
11 BIRTHPLACE (County & State, or foreign country) Baltimore County		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Amos Widerman		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. NONE	
17 INFORMANT Francis C. Smink		Address 3120 Rolling Road	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial C.V. Disease - CVA DUE TO 1 day (b) Arteriosclerotic disease - generalized DUE TO 15 yrs (c) Coronary Insufficiency 1 YEAR		INTERVAL BETWEEN ONSET AND DEATH 15 yrs 1 YEAR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 1950 to NOV 3 1966 , that (I) (we) last saw the deceased alive on NOV 3 1966 , and that death occurred at 10:30 AM from causes and on the date stated above.			
22a SIGNATURE Thomas E. Wheeler		22b DATE SIGNED 11-4-66	
22c PHYSICIAN'S NAME (Type) THOMAS E. WHEELER		22d ADDRESS 3601 CHESTER RD - BALTO 7 MD	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11-7-66	
23c NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore Maryland	
24 FUNERAL DIRECTOR Ellsworth		25a REC'D BY REGISTRAR DATE NOV 7 1966	
25b REGISTRAR'S SIGNATURE Charles Jones			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15749

CERTIFICATE OF DEATH

15752

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u> 13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 45A Guilford Rd</u>		d. STREET ADDRESS <u>Box 45A Guilford Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>James</u> Middle <u>Taylor</u> Last		4. DATE OF DEATH <u>November 29</u> 19 <u>66</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 13 1889</u> 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WABPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cotton mill</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hannan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Ozella Taylor Jessup Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 502.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Bronchitis</u> DUE TO (c) <u>Emphysema</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs.</u> <u>15 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/28</u> , 19 <u>66</u> , to <u>11/29</u> , 19 <u>66</u> that (I) (<u>we</u>) last saw the deceased alive on <u>11/29</u> , 19 <u>66</u> , and that death occurred at <u>2 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J M Warren</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J M Warren</u>		22d. ADDRESS <u>LAUREL Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/2/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem Park Laurel Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>De Witt Canadian Laurel Md.</u> ADDRESS		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>DEC 3 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10000

15758

RECEIVED

Charles Taylor

George B. Branch
Branch

J. H. W. W. W. W. W.
T. H. W. W. W. W. W.
T. H. W. W. W. W. W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY Howard b. STATE Maryland c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 338 Columbia Pike					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS 338 Columbia Pike e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MAY ELIZABETH TITTSWORTH First Middle Last 4. DATE OF DEATH Nov. 12, 1966 Month Day Year					5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Aug. 2, 1897 9. AGE (In years last birthday) 69 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Ellicott City, Md 12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME Crawford Moxley 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. ? 17. INFORMANT Roger H. Tittsworth, Ellicott City, Md Address					14. MOTHER'S MAIDEN NAME Mary Etta Elizabeth Webb				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST 170X CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) CARCINOMATOSIS - (c) CARCINOMA, Breast - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus. INTERVAL BETWEEN ONSET AND DEATH 2 Mo. 4 Mo.									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 11-9 1966 to 11-12, 1966 that (I) (we) last saw the deceased alive on 11-9 1966 and that death occurred at 12:30 PM from the causes and on the date stated above. 22a. SIGNATURE <i>John V. Thacker</i> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS 22e. MED. DIRECTOR <input type="checkbox"/> 22f. STAFF PHYS. <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 11-15-1966 23c. NAME OF CEMETERY OR CREMATORY St. Johns 23d. LOCATION (City, town or county) Ellicott City, Md (State)									
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md. 25a. REC'D BY REGISTRAR NOV 14 1966 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

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Howard

Howard

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